DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445298	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF ATHENS	1234 FRYE STREET, PO BOX 788 ATHENS, TN 37371

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed ensure no more than 1 delayed egress door in any path of the egress. The findings include: Observation on August 12, 2013 at 12:05 p.m. revealed the door leading into the Alzheimer's wing is labeled as an exit and is magnetically locked by a delayed egress lock. Once you enter the Alzheimer's wing through the delayed egress door, the exit access takes you to the end of the hall to the next exit door that is magnetically locked with delayed egress that leads outside to the public way. This finding was verified by the maintenance director and acknowledged by administration during the exit conference on August 12, 2013.	K 038	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The door leading into the Alzheimer's wing was assessed by the Director of Maintenance for correction on 8/12/13. Documentation will be submitted for desk review to the Department of Health Construction and Plans Review by 8/30/13. Locking arrangement(s) will be changed within five days from receipt of Department of Health Construction approval. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents that reside in the facility have the potential to be affected. All facility exits will be inspected by the Director of Maintenance by 8/26/13 to ensure compliance with NFPA 101 - 2000 locking arrangements. **What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur;** The Director of Maintenance will inspect exit locking arrangements quarterly and document in the facility's Preventive Maintenance Log to ensure compliance with NFPA 101 - 2000 locking arrangements. **How the corrective action(s) will be monitored to ensure the deficient practice**	09/26/13
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided	K 051		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Executive Director 8/27/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 051	Continued From page 1 that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure smoke detectors were located at least 3 feet from air flow. The findings include: Observation on August 12, 2013 at 10:30 a.m. revealed the following locations has smoke detectors within 3 feet of air flow: 1. Corridor by room 133. 2. Corridor by room 122. 3. Corridor by room 104. 4. Medical records room. 5. Corridor by room 221. 6. Corridor by room 232. These findings were verified by the maintenance director and acknowledge by administration during the exit conference on August 12, 2013.	K 051	**will not recur; i.e., what quality assurance program will be put into place.** Preventive Maintenance Log will be reported by the Director of Maintenance to the Performance Improvement Committee quarterly for 3 quarters or until 100% compliance is achieved. The Performance Improvement Committee will review these results; and if deemed necessary by the committee, additional corrective action(s), measures, and/or systematic changes may be initiated. K051 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The smoke detectors located in the corridors near rooms 133, 122, 104, 221, and 232 and in the medical records room were relocated by contracted electrician on 8/12/13. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents that reside in the facility have the potential to be affected. All smoke detectors located near diffusers/air flow were audited by the Director of Maintenance on 8/21/13 to ensure that smoke detectors are located at least 3 feet from air flow. Director of Maintenance and Assistant Director of Maintenance were educated by the Executive Director on 8/21/13 to ensure that smoke detectors are located at least 3 feet from air flow.	09/26/13

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			What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; Life safety systems contractor will audit all smoke detectors located near diffusers/air flow semi-annually to ensure that smoke detectors are located at least 3 feet from air flow. Assistant Director of Maintenance and/or Director of Maintenance will audit all smoke detectors located near diffusers/air flow weekly X4 and monthly X2 to ensure that smoke detectors are located at least 3 feet from air flow. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** Audit results will be reported by the Director of Maintenance to the Performance Improvement Committee monthly for 3 months or until 100% compliance is achieved. The Performance Improvement Committee will review these results; and if deemed necessary by the committee, additional corrective action(s), measures, and/or systematic changes may be initiated.	